

STATE OF HAWAII, DEPARTMENT OF HEALTH
OFFICE OF HEALTH STATUS MONITORING

REQUEST FOR ☐ VERIFICATION ☐ CERTIFIED COPY OF **DIVORCE RECORD**

HUSBAND'S NAME:	FIRST	MIDDLE	LAST
WIFE'S NAME:	FIRST	MIDDLE	MAIDEN NAME
DATE OF DIVORCE:	MONTH	DAY	YEAR
PLACE OF DIVORCE:	CITY OR TOWN		ISLAND
RELATIONSHIP OF REQUESTOR TO PERSON NAMED ON CERTIFICATE		REASON FOR THIS REQUEST	
SIGNATURE OF REQUESTOR:			TELEPHONE NUMBERS RES: BUS:
PRINT NAME OF REQUESTOR:			
ADDRESS OF REQUESTOR: NO. AND STREET OR P.O. BOX			
CITY		STATE	ZIP

<u>FEES</u>	
<u>CERTIFIED COPIES:</u>	
_____ FIRST COPY AT \$10.00	= \$ _____
_____ ADDITIONAL COPIES AT \$4.00 EACH	= \$ _____
_____ TOTAL COPIES	TOTAL AMOUNT DUE = \$ _____
<u>VERIFICATION:</u>	
_____ COPIES AT \$5.00 EACH	TOTAL AMOUNT DUE = \$ _____
GRAND TOTAL DUE = \$ _____	

FOR OFFICE USE ONLY			
_____ NR FILE _____ PENDING:			
INDEX SEARCHED FROM TO		VOLUMES SEARCHED FROM TO	
DATE COPY PREPARED			
YEAR	VOLUME	CERTIFICATE	RECEIPT NUMBER